		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.

IDPH Facility ID Number: 0041608

Facility Name: ASTA CARE CENTER OF ELGIN

Address: 134 N. MCCLEAN BOULEVARD (Number) ELGIN (City) 60123 (Zip Code)

County: KANE

Telephone Number: (847) 742-8822 **Fax #** (847) 742-9013

IDPA ID Number: 36-4069629

Date of Initial License for Current Owners: 03/29/96

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[X]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) MICHAEL GILLMAN

(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	52	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,826	1,826	8
9	SNF/PED					9
10	ICF	22,682	6,264	631	29,577	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,682	6,264	2,457	31,403	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.35%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/29/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/29/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 1,826

Medicare Intermediary ADMINISTAR OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	205,809	18,862	5,445	230,116		230,116		230,116			1
2	Food Purchase		111,591		111,591		111,591	(2,256)	109,335			2
3	Housekeeping	164,915	22,783		187,698		187,698		187,698			3
4	Laundry	45,911	11,626	1,438	58,975		58,975		58,975			4
5	Heat and Other Utilities			78,730	78,730		78,730		78,730			5
6	Maintenance	33,108	23,818	27,361	84,287		84,287	1,602	85,889			6
7	Other (specify):* Scavenger			18,059	18,059		18,059		18,059			7
8	TOTAL General Services	449,743	188,680	131,033	769,456		769,456	(654)	768,802			8
	B. Health Care and Programs											
9	Medical Director			7,750	7,750		7,750		7,750			9
10	Nursing and Medical Records	964,852	53,778	8,707	1,027,337		1,027,337		1,027,337			10
10a	Therapy	116,781	1,162	2,391	120,334		120,334		120,334			10a
11	Activities	62,761	7,434	1,860	72,055		72,055		72,055			11
12	Social Services	36,185		3,240	39,425		39,425		39,425			12
13	Nurse Aide Training											13
14	Program Transportation			275	275		275		275			14
15	Other (specify):* RX DRUGS											15
16	TOTAL Health Care and Programs	1,180,579	62,374	24,223	1,267,176		1,267,176		1,267,176			16
	C. General Administration											
17	Administrative	30,197		166,000	196,197		196,197	(1,827)	194,370			17
18	Directors Fees											18
19	Professional Services			31,948	31,948		31,948	998	32,946			19
20	Dues, Fees, Subscriptions & Promotions			30,325	30,325		30,325	(20,648)	9,677			20
21	Clerical & General Office Expenses	145,066	19,607	22,595	187,268		187,268	607	187,875			21
22	Employee Benefits & Payroll Taxes			264,928	264,928		264,928		264,928			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,364	3,364		3,364	102	3,466			24
25	Other Admin. Staff Transportation			2,952	2,952		2,952	2,262	5,214			25
26	Insurance-Prop.Liab.Malpractice			75,442	75,442		75,442	1,842	77,284			26
27	Other (specify):* Bad Debts			783	783		783	7,494	8,277			27
28	TOTAL General Administration	175,263	19,607	598,337	793,207		793,207	(9,170)	784,037			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,805,585	270,661	753,593	2,829,839		2,829,839	(9,824)	2,820,015			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN #0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			32,196	32,196		32,196	(8,170)	24,026			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,715	33,715		33,715	979	34,694			32
33	Real Estate Taxes			64,917	64,917		64,917		64,917			33
34	Rent-Facility & Grounds			343,536	343,536		343,536		343,536			34
35	Rent-Equipment & Vehicles			22,127	22,127		22,127	1,232	23,359			35
36	Other (specify):*			374	374		374		374			36
37	**TOTAL Ownership**			496,865	496,865		496,865	(5,959)	490,906			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,298	124,614	187,912		187,912		187,912			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		63,298	180,459	243,757		243,757		243,757			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,805,585	333,959	1,430,917	3,570,461		3,570,461	(15,783)	3,554,678			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,481)	30		9
10	Interest and Other Investment Income	(97)	32		10
11	Discounts, Allowances, Rebates & Refunds	(438)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,818)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(8,294)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(783)	27		24
25	Fund Raising, Advertising and Promotional	(12,740)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(29,319)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (60,970)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	45,187		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 45,187		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (15,783)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ASTA CARE CENTER OF ELGIN

ID# 0041608

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1,602	6	1
2	BANK CHARGES	(3,594)	21	2
3	MARKETING SALARY	(26,638)	21	3
4	NON-CARE DEPRECIATION EXPENSE	(689)	30	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(29,319)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,256)	0	0	0	0	0	0	0	0	0	0	(2,256)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,602	0	0	0	0	0	0	0	0	0	0	1,602	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(654)	0	0	0	0	0	0	0	0	0	0	(654)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(1,827)	0	0	0	0	0	0	0	0	0	(1,827)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	998	0	0	0	0	0	0	0	0	0	998	19
20	Fees, Subscriptions & Promotions	(21,034)	386	0	0	0	0	0	0	0	0	0	(20,648)	20
21	Clerical & General Office Expenses	(30,232)	30,839	0	0	0	0	0	0	0	0	0	607	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	102	0	0	0	0	0	0	0	0	0	102	24
25	Other Admin. Staff Transportation	0	2,262	0	0	0	0	0	0	0	0	0	2,262	25
26	Insurance-Prop.Liab.Malpractice	0	1,842	0	0	0	0	0	0	0	0	0	1,842	26
27	Other (specify):*	(783)	8,277	0	0	0	0	0	0	0	0	0	7,494	27
28	**TOTAL General Administration**	(52,049)	42,879	0	0	0	0	0	0	0	0	0	(9,170)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(52,703)	42,879	0	0	0	0	0	0	0	0	0	(9,824)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN **#** 0041608 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,170)	0	0	0	0	0	0	0	0	0	0	(8,170)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(97)	1,076	0	0	0	0	0	0	0	0	0	979	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,232	0	0	0	0	0	0	0	0	0	1,232	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,267)	2,308	0	0	0	0	0	0	0	0	0	(5,959)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(60,970)	45,187	0	0	0	0	0	0	0	0	0	(15,783)	45

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		LIST ATTACHED		ASTA HEALTHCARE	ELGIN	MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 166,000			$	$ (166,000)	1
2	V	17					14,990	14,990	2
3	V	17					149,183	149,183	3
4	V	19					998	998	4
5	V	20					386	386	5
6	V	21					30,839	30,839	6
7	V	24					102	102	7
8	V	25					2,262	2,262	8
9	V	26					1,842	1,842	9
10	V	27					8,277	8,277	10
11	V	32					1,076	1,076	11
12	V	35					690	690	12
13	V	35					542	542	13
14	Total			$ 166,000			$ 211,187	$ * 45,187	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SEE ATTACHED								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ASTA HEALTHCARE COMPANY
Street Address: 134 NORTH MCLEAN BLVD
City / State / Zip Code: ELGIN, IL 60123
Phone Number: (847) 742 - 8822
Fax Number: (847) 742 - 9013

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SALARIES	PATIENT DAYS	167,599	6	$ 80,000	$ 80,000	31,403	$ 14,990	1
2	17	OFFICER SALARIES	DIRECT	2	2	80,000	80,000	0	0	2
3	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	167,599	6	195,246	195,246	31,403	36,583	3
4	17	ADMINISTRATIVE SALARIES	DIRECT	1	1	41,574	41,574	0	0	4
5	17	ADMINISTRATIVE SALARIES	DIRECT	1	1	112,600	112,600	1	112,600	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	167,599	6	5,324		31,403	998	6
7	20	LICENSES & PERMITS	PATIENT DAYS	167,599	6	2,062		31,403	386	7
8	21	OFFICE EXPENSE	PATIENT DAYS	167,599	6	164,588	128,291	31,403	30,839	8
9	24	EDUCATION & SEMINARS	PATIENT DAYS	167,599	6	545		31,403	102	9
10	25	TRANSPORTATION	PATIENT DAYS	167,599	6	12,073		31,403	2,262	10
11	26	INSURANCE	PATIENT DAYS	167,599	6	9,832		31,403	1,842	11
12	27	PAYROLL TAXES,HEALTH IN	PATIENT DAYS	167,599	6	44,177		31,403	8,277	12
13	32	INTEREST EXPENSE	PATIENT DAYS	167,599	6	5,745		31,403	1,076	13
14	35	COPIER LEASE	PATIENT DAYS	167,599	6	3,681		31,403	690	14
15	35	AUTO LEASE	PATIENT DAYS	167,599	6	2,893		31,403	542	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 760,340	$ 637,711		$ 211,187	25

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4	RELATED PARTY-ASTA	X									1,076	4
5	ASTA MANAGEMENT	X		WORKING CAPITAL							5,333	5
	Working Capital											
6	BANK 1		X	WORKING CAPITAL	INTEREST	REVOLV	375,000	480,000	REVOLV	PRIME+	25,163	6
7	A.I. CREDIT VORP		X	INT ON INSUR POLICIES							1,549	7
8	WELLS FARGO		X	ALARM SYSTEM	$614.00	1/20/02	36,870	30,111			1,670	8
9	TOTAL Facility Related				$614.00		$ 411,870	$ 510,111			$ 34,791	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 411,870	$ 510,111			$ 34,791	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 61,231	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 76,122	2
3. Under or (over) accrual (line 2 minus line 1).		$ 14,891	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 50,122	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 96 For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (96)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 64,917	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	55,610	8
	1998	56,561	9
	1999	59,779	10
	2000	61,231	11
	2001	63,122	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL MINUS $13000 PREPAID FOR 2002'S BILL

THE PAYMENT ON LINE 2 APPLIES TO $63,122 FOR 2001 AND $13,000 FOR 2002

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible] Office of Health Finance at (217) 782-1600.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF ELGIN COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0041608

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-15-176-044	NURSING HOME	$ 4,726.00	$ 4,726.00
2.	06-15-176-043	NURSING HOME	$ 732.00	$ 732.00
3.	06-15-176-011	NURSING HOME	$ 57,664.00	$ 57,664.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 63,122.00	$ 63,122.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOOR DRAIN			1997	1,297	33	39	33		183	9
10	INSTALL SHOWER VALVE AND DRAIN			1997	4,142	105	39	105		583	10
11	RE KEY DOOR LOCKS			1997	4,085	104	39	104		577	11
12	NEW AIR VENTS			1997	616	18	39	18		99	12
13	FIRE ALARM SYSTEM			1997	2,192	56	39	56		310	13
14	AWNINGS			1997	1,020	26	39	26		144	14
15	SEWAGE EJECTOR PUMP			1998	3,961	102	39	102		471	15
16	HOT WATER PUMP			1998	5,439	139	39	139		585	16
17	AWNINGS			1999	685	25	27.5	25		89	17
18	FLOORING			1999	2,474	90	27.5	90		319	18
19	ELECTRICAL WORK			1999	9,378	341	27.5	341		1,208	19
20	MAGNETIC DOOR LOCKS			1999	2,054	74	27.5	74		262	20
21	FIRE SPRINKLER SYSTEM			1999	3,868	141	27.5	141		499	21
22	BOILER			1999	4,890	178	27.5	178		630	22
23	NURSE STATION			2000	16,280	592	27.5	592		1,505	23
24	CONDENSING UNIT			2000	4,683	170	27.5	170		432	24
25	WATER HEATER			2000	8,731	317	27.5	317		806	25
26	POWER VENT FOR WATER HEATER			2000	2,682	98	27.5	98		249	26
27	NEW WALLS			2000	2,000	73	27.5	73		185	27
28	HOT WATER PIPING			2000	4,708	171	27.5	171		435	28
29	DRAPERIES			2000	2,303	371	7	371		1,377	29
30	EJECTOR PUMP			2001	14,041	511	27.5	511		788	30
31	ROOF			2001	6,218	226	27.5	226		348	31
32	COMPRESSOR			2001	3,501	127	27.5	127		196	32
33	PRESSURE BACK FLOW PREVENTER			2002	3,870	76	27.5	76		76	33
34	FIRE ALARM SYSTEM			2002	37,625	741	27.5	741		741	34
35	RE KEY LOCKS			2002	1,346	27	27.5	27		27	35
36	PATIENT SECURITY SYSTEM			2002	2,719	53	27.5	53		53	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	2002	$ 4,864	$ 96	27.5	$ 96	$	$ 96	37
38	NEW PIPE	2002	1,575	31	27.5	31		31	38
39	VINYL FLOORING	2002	17,779	7,823	5	3,556	(4,267)	3,556	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 181,026	$ 12,935		$ 8,668	$ (4,267)	$ 16,860	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 146,375	$ 12,225	$ 14,637	$ 2,412	10	$ 72,008	71
72	Current Year Purchases	14,425	6,347	721	(5,626)	10	721	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 160,800	$ 18,572	$ 15,358	$ (3,214)		$ 72,729	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 341,826	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 31,507	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,026	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,481)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 89,589	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	FURNITURE	$ 7,768	$ 689	$ 6,131	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 7,768	$ 689	$ 6,131	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ELGIN NURSING HOME PROPERTY LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		102	03/26/96	$ 343,536	30		3
4	Additions							4
5								5
6								6
7	TOTAL		102		$ 343,536 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 03/26/96
Ending 03/26/26

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ 454,607
13.	/2004	$ 461,862
14.	/2005	$ 461,862

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 11,699 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT,HSK,ACT.	1999 FORD BUS SUP-	$ 681.00	$ 10,428	17
18		REME			18
19					19
20					20
21	TOTAL		$ 681.00	$ 10,428	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs		$		$ 34,543	$		$ 34,543	1
2	Licensed Speech and Language Development Therapist	39-8	hrs				9,176			9,176	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-8	hrs				50,004			50,004	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts					52,093		52,093	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): LAB, SUPPLIES	39-8					30,891	11,205		42,096	13
14	TOTAL				$		$ 124,614	$ 63,298		$ 187,912	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 127,356	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	538,536		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,318		6
7	Other Prepaid Expenses	3,575		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE ESCROW	33,166		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 717,951	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	181,026		15
16	Equipment, at Historical Cost	160,800		16
17	Accumulated Depreciation (book methods)	(160,987)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): COMP SOFT	14,738		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 195,577	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 913,528	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 139,995	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	527		28
29	Short-Term Notes Payable	480,000		29
30	Accrued Salaries Payable	30,293		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,459		31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,122		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTIES	150,814		36
37	DUE TO WELLS FARGO	30,111		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 887,321	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	561,408		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 561,408	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,448,729	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (535,201)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 913,528	$	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (634,685)	1
2	Restatements (describe):		2
3	ROUNDING	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (634,687)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	99,486	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 99,486	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (535,201)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,610,689	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,610,689	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	55,072	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 55,072	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,651	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,651	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	INTEREST INCOME	97	28
28a	DISCOUNT EARNED	438	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 535	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,669,947	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	769,456	31
32	Health Care	1,267,176	32
33	General Administration	793,207	33
	B. Capital Expense		
34	Ownership	496,865	34
	C. Ancillary Expense		
35	Special Cost Centers	187,912	35
36	Provider Participation Fee	55,845	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,570,461	40
41	**Income before Income Taxes (line 30 minus line 40)****	99,486	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 99,486	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.** **TAX RETURN CASH BASIS**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,094	2,351	$ 103,427	$ 43.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,829	12,604	316,324	25.10	3
4	Licensed Practical Nurses	2,063	2,099	38,069	18.14	4
5	Nurse Aides & Orderlies	42,582	43,306	477,118	11.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,367	4,653	116,781	25.10	8
9	Activity Director	2,347	2,509	27,554	10.98	9
10	Activity Assistants	4,481	4,887	35,207	7.20	10
11	Social Service Workers	2,416	2,643	36,185	13.69	11
12	Dietician					12
13	Food Service Supervisor	2,029	2,281	34,795	15.25	13
14	Head Cook	12,770	14,163	124,266	8.77	14
15	Cook Helpers/Assistants	6,046	6,519	46,748	7.17	15
16	Dishwashers					16
17	Maintenance Workers	2,009	2,257	33,108	14.67	17
18	Housekeepers	20,590	22,374	164,915	7.37	18
19	Laundry	6,188	6,721	45,911	6.83	19
20	Administrator	614	872	30,197	34.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,185	3,413	76,959	22.55	23
24	Clerical	3,836	4,495	68,107	15.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,080	2,080	29,914	14.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	131,526	140,227	$ 1,805,585 *	$ 12.88	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 4,400	1-3	35
36	Medical Director	O	7,750	9-3	36
37	Medical Records Consultant	N	1,472	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	600	10-3	39
40	Physical Therapy Consultant	L	1,022	10a-3	40
41	Occupational Therapy Consultant	Y	824	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,860	11-3	44
45	Social Service Consultant	E	3,240	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,168		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses	47	1,645	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	47	$ 1,645		53

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KAREN KEMP	ADMIN	0	$ 30,197
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 30,197

B. Administrative - Other

Description	Amount
ASTA HEALTH CARE MNGT - MANAGEMENT FEE	$ 166,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 166,000

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		31,948
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 31,948

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,108
Unemployment Compensation Insurance	17,007
FICA Taxes	132,917
Employee Health Insurance	70,605
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	9,477
EMPLOYEE PHYSICAL EXAMS	814
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 264,928

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,235
Health Care Worker Background Check	560
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	12,740
TRUST/FRANCHISE/CONTRIB/ETC	8,294
LICENSES & PERMITS	803
DUES & SUBSCRIPTIONS	4,693
MGMT CO ALLOCATION	386
TRUST/FRANCHISE/CONTRIB/ETC	(8,294)
Less: Public Relations Expense	(0)
Non-allowable advertising	(12,740)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,677

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	3,364
RELATED PARTY-SEMINARS	102
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,466

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT / DECORATING	1997	$ 4,534	3	$ 1,511	$ 756	$	$	$	$	$	$	$
2	PAINT / DECORATING	1998	1,623	3	541	541	270						
3	PAINT / DECORATING	1999	1,843	3	307	614	614	308					
4	PAINT / DECORATING	2000	7,149	3		1,192	2,383	2,383	1,191				
5	PAINT / DECORATING	2001	3,139	3			524	1,046	1,046	523			
6	PAINT / DECORATING	2002	2,562	3				427	854	854	427		
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 20,850		$ 2,359	$ 3,103	$ 3,791	$ 4,164	$ 3,091	$ 1,377	$ 427	$	$

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC $5,952.**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,623** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,845**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: ASTA CARE CENTER OF ELGIN #0041608 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,400	
	REPAIRS & MAINTENANCE		600	
	OUTSIDE SERVICES		445	5,445
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,438	
			0	1,438
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		19,545	
	ELECTRICITY		38,031	
	WATER		21,020	
	CABLE TV - LOBBY		134	
			0	78,730
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,596	
	PAINTING & DECORATING		2,562	
	BUILDING REPAIRS		1,056	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,389	
	ELEVATOR MAINTENANCE & REPAIR		2,315	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,700	
	FIRE SERVICE		9,743	
			0	
			0	
			0	27,361
7	**OTHER**			
	SCAVENGER		18,059	
	SECURITY SERVICE		0	18,059
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,750	7,750

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	1,645	
	LABORATORY & XRAY EXPENSE		52	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	384	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,472	
	PHARMACY CONSULTANT	XVIII B 39-2	600	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	41	
	PSYCHIATRIC	XVIII B __-2	1,350	
	RN CONSULTANT	XVIII B 38-2	0	
	PROGRAM CONSULTANT		3,701	
	COSTS REBILLED		(538)	8,707
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		545	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,022	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	824	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	2,391
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,860	
			0	1,860
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	384	
	SOCIAL WORKER	XVIII B 45-2	2,856	
			0	3,240
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER OF ELGIN #0041608 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		275	275
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	166,000	166,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,306	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	26,642	
			0	31,948
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	12,740	
	EMPLOYEE WANT ADS	XIX F	3,235	
	CONTRIBUTIONS	VI 20 XIX F	6,125	
	DUES & SUBSCRIPTIONS	XIX F	4,693	
	LICENSES & PERMITS	XIX F	803	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,169	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	560	30,325
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,594	
	EQUIPMENT REPAIR & MAINTENANCE		261	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		23,355	
	MESSENGER SERVICE		746	
	COST REBILLED		(5,361)	22,595

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	132,917	
	UNEMPLOYMENT COMPENSATION	XIX D	17,007	
	WORKERS COMPENSATION INSURANC	XIX D	34,108	
	HOSPITALIZATION INSURANCE	XIX D	70,605	
	EMPLOYEE BENEFITS - OTHER	XIX D	9,477	
	EMPLOYEE PHYSICAL EXAMS	XIX D	814	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	264,928
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,364	
	TRAVEL	XIX G	0	
			0	
			0	3,364
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,952	2,952
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		75,442	75,442
27	**OTHER**			
	BAD DEBTS	VI 24	783	
			0	783

GRAND TOTAL COLUMN 3 OTHER 753,593

ASTA CARE CENTER OF ELGIN
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	111,591	PATIENT MEALS	94209
LESS SALES TAX	(1,818)	ADD EMPLOYEE MEALS	0
NET FOOD	109,773	TOTAL MEALS/YEAR	94209
TOTAL PATIENT CENSUS	31,403	NET FOOD	109773
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	94209
TOTAL PATIENT MEALS	94209	COST PER MEAL	1.17
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		